GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

FY 2016 Budget Hearing

Testimony of

Wayne Turnage

Director

Department of Health Care Finance

Before the

Council of the District of Columbia

Committee on Health and Human Services

April 17, 2015

John A. Wilson Building

1350 Pennsylvania Avenue, NW

Introduction

Good morning Chairwoman Alexander and members of the Committee on Health and Human Services. I am Wayne Turnage, Director of the Department of Health Care Finance (DHCF) and it is my pleasure today to FY2016 budget entitled

As Mayor Bowser recently testified before the Council, each agency plays a critical part in ensuring that District residents in all 8 Wards have the education, economic opportunity, public safety, neighborhoods, environment, and infrastructure they need to reach the middle class. Y2016 Budget submission will ensure that our agency and the entire government have the necessary staff and resources to help meet these ambitious goals.

This budget is the product of an unprecedented amount of outreach. The Mayor held three budget engagement forums attended by hundreds of residents that described how they would allocate resources

met with Councilmembers and their staff to incorporate their priorities in the budget. Finally, the Mayor and her senior leadership met with numerous community groups as part of the development of this budget. All of this work on the front end of this process gave us a much better budget as a result and we will continue that kind of outreach, transparency, and accountability to fine tune and implement the FY2016 budget.

In developing the Executive budget for the District of Columbia, Mayor Bowser confronted a number of challenges which prominently included the pressing problem of a $193 million budget gap. Despite local fund growth which was 3.1 percent higher than FY2015 revenues, the budget gap surfaced due to higher than anticipated cost increases for a number of factors central to the operation of District government. Specifically, employee salaries, the expense of debt service, the expanding cost of the Medicaid program, and the impact of general

inflation were just a few of the factors that contributed to a steeper rate of cost growth than was budget.

As has been previously documented, with our more than $700 million local fund budget, portfolio of spending, second only to the District of Columbia Public School System. And when you consider both federal and local funds combined, DHCF has the largest budget in District government. Accordingly, as the Administration pursued gap closing measures, by necessity, considerable attention had to be directed towards the programs funded through DHCF and the associated or underlying cost drivers.

With such a significant allocation of local funds, a series of reduction strategies executed within promise of savings and relief from some of the fiscal pressures. However, these strategies must be designed and implemented in such a way to minimize the adverse impact on beneficiaries and the providers who afford access to the health care services funded through the Medicaid and Alliance programs.

This task is complicated due to the $3 billion annually, fully 96 percent of this spending can be traced to provider payments which are directly influenced by beneficiary utilization levels, the scope of authorized benefits, and rate reimbursement decisions. The remaining four percent of the budget funds contractual services that are central to the operation of our programs as well as employee salaries which are significantly underwritten by federal funds. Thus, major savings in either the Medicaid or Alliance programs can typically only be accomplished through changes in participant eligibility levels, the scope of recipient benefits, or provider reimbursements.

I am pleased to report that the Mayor has executed a thoughtful, balanced, and sensible savings strategy for DHCF to achieve her budget goals in FY2016. Through targeted provider reimbursement savings, resourceful policy changes, and the judicious leveraging of federal dollars, the Mayor was able to identify more than $41.4 million in DHCF local fund savings. More importantly, this was accomplished while preserving the hallmarks

safety net health care programs high levels of participant eligibility combined with a comprehensive array of benefits.

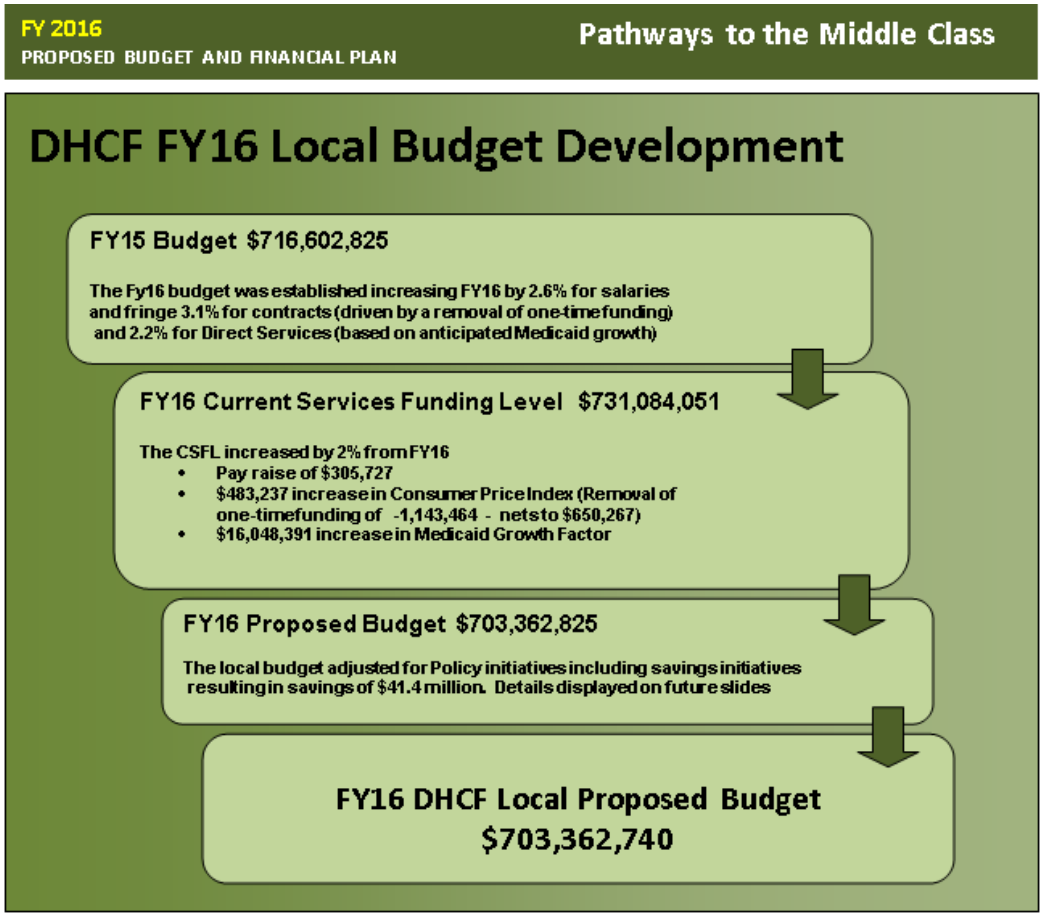
My remarks today initially focus on three issues that shaped our budget development for FY

FY2015 authorized budget and the impact of the FY2016 Current Services Funding Level (CSFL). Second, I will outline some of the key savings strategies authorized by Mayor Bowser to generate $41.4 in local fund savings. Particular attention is given to discussing the rationale underpinning the selection of several of these strategies and the reasons we believe they will have no adverse impact on beneficiaries access to quality health care in the Medicaid program. Third, a brief summary is provided of the legislative steps that must be executed to ensure a timely implementation of the savings initiatives.

I close out my testimony with a report on a few of the broad spending trends in the Medicaid program paying special attention to the policy issues that are inherent in these numbers. We must and will address these issues in the coming months and through FY2016.

DHCF'S Budget Development Process

Madam Chairwoman, the illustration on page 5 of my testimony outlines the steps we budget for DHCF. As shown, the Mayor relied upon DHCF budget of $716.6 million to set the base funding level in FY2016.



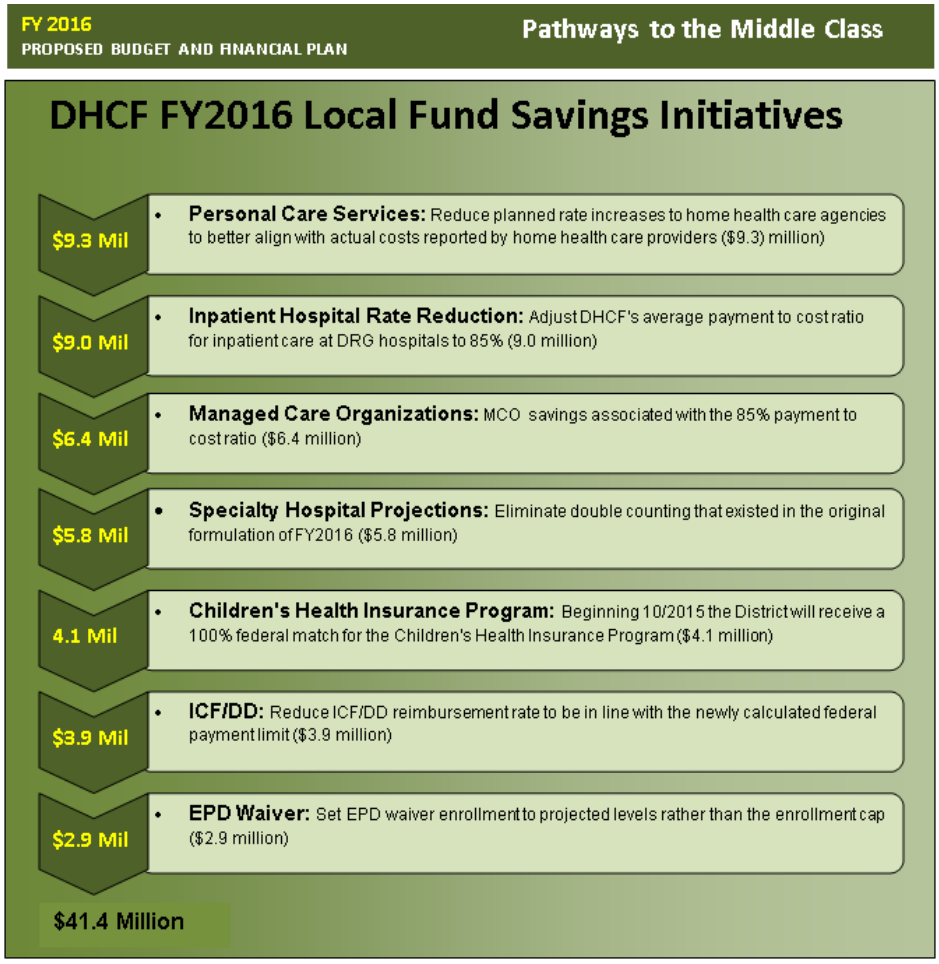
Next, to derive the CSFL of $731 million for FY2016, th budget amount was inflated by employee salaries and fringe benefits, anticipated growth in Medicaid direct services, and the Consumer Price Index. Descriptively, the CSFL reflects the cost of providing the same services in FY2016 that were funded in FY2015 before any policy changes are proposed.

The most significant increase from the FY2015 base budget was a 2.2 percent adjustment to fund direct health care services which total more than $15 million. This represents the combined effect of the anticipated growth in beneficiary enrollment, utilization, and heath care inflation. Although other factors had larger percentage adjustments, this increase for Medicaid direct care accounted for the greatest absolute increase in actual dollars by a considerable margin, pushing the FY2016 proposed budget to $731 million before any downward adjustments.

DHCF Proposed Savings Initiatives

As a initiatives. Three of the more significant strategies call for provider rate adjustments. Two of the proposed actions will take advantage of savings based on anticipated utilization patterns and more detailed data on the impact of contracting changes in the managed care program. Another initiative was based on a change in federal policy.

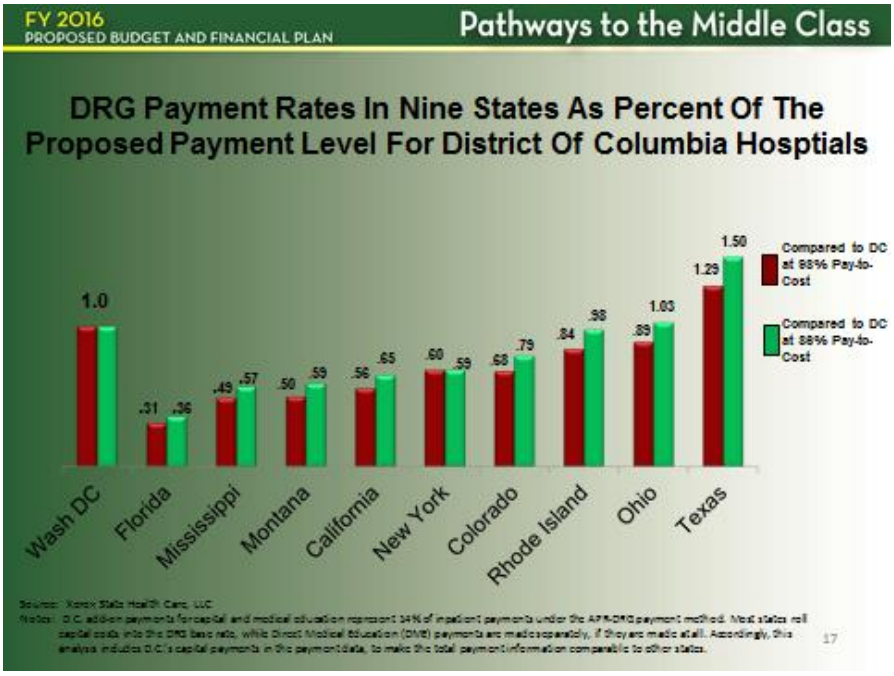
The figure on page 6 lists all seven strategies and the savings associated with each initiative which, as noted earlier, total $41.4 million. The changes made to provider reimbursement warrant special mention - in particular the reduction in the Medicaid payment rate for hospitals.



Currently, the District of Columbia funds hospitals at 98% of their reported allowable cost for serving the Medicaid Fee-For-Service (FFS) population. This is one of the highest reimbursement rates in the country and only 2 percent less than the maximum amount a Medicaid State agency can pay for inpatient care.

86% of cost, there is no indication that this payment amount is inadequate. Even at 86% of cost, DC maintains an inpatient hospital payment rate -- excluding Disproportionate Share Payments (DSH) -- that is roughly equal to a nationwide average which includes DSH Payments. To that point, the 2013 nationwide average Medicaid payment to cost ratio for hospitals with DSH funds included was 87%.

Also, we have reviewed the inpatient hospital rates for States with similar payment systems as the District. And with the proposed reduction, DC maintains an inpatient hospital operating payment that is higher than two-thirds of States with comparable reimbursement systems. As the graphic on page 7 shows, only two states (Ohio and Texas) have a DRG base operating payment (with capital added in) that is higher than the District.



We are similarly confident that the savings initiative for the personal care program is appropriate, fair, and without adverse consequences to the industry. The key fact here is that the proposed savings of $9.3 million do not eliminate a planned rate increase for this service in FY2016. In preparation for this reimbursement policy change during the budget development

objectively identify the allowable cost of this service.

Subsequent to this action, we asked home health care agencies to submit cost reports detailing the expenses associated with implementing the Medicaid personal care program. In turn, we have engaged an independent firm to audit these cost reports before we develop the FY2016 personal care rates for the industry. However, I asked my finance team to examine these reports in some detail to provide an early indication of reported cost trends. Based on this preliminary review, we were better able to align our current budget assumptions with the estimated cost of personal care and this generated the local savings amount proposed in the

.

The final provider savings amount that should be discussed is the $2.9 million reduction

t is important to note

that this savings amount is not premised on a reduction in EPD services. As a waiver service, the EPD program is authorized to provide only a certain number of slots frequently referred to as the cap. In years past, DHCF has budgeted sufficient dollars to funds all the slots up to the cap, regardless of the projected utilization for the program. For FY2016, however, DHCF is proposing a budget based on anticipated utilization which is the basis for the planned savings amount.

While the process for gaining admission to the EPD program is protracted (and is being re-engineered), presently, there is no back log of applications. If we find during the fiscal year that actual utilization exceeds the projected trend, no one will be denied services unless and until the number of authorized slots for the program -- the cap -- is completely occupied. At that point a waiting list will be formed as is the process in other states. Should DHCF be required to fund any unanticipated utilization, possibly up to the cap, we will first seek to do so from any emerging savings during FY2016 which emanate from other service lines. If those savings do not materialize, we would look to reprogram funds from savings in other agencies.

Legislative Action Needed To Facilitate Implementation of Savings Strategies

In order to ensure the proposed policy changes are implemented in time to align with the FY 2016 budget, the agency requires passage of the Budget Support Act (BSA) with specific language authorizing the necessary Medicaid State Plan Amendments (SPA) needed for the modifications being proposed to the Medicaid reimbursement payment methodologies. Passage of the BSA would also constitute the necessary approval by Council prior to the submission of SPA changes to our regulator, the Center for Medicare and Medicaid.

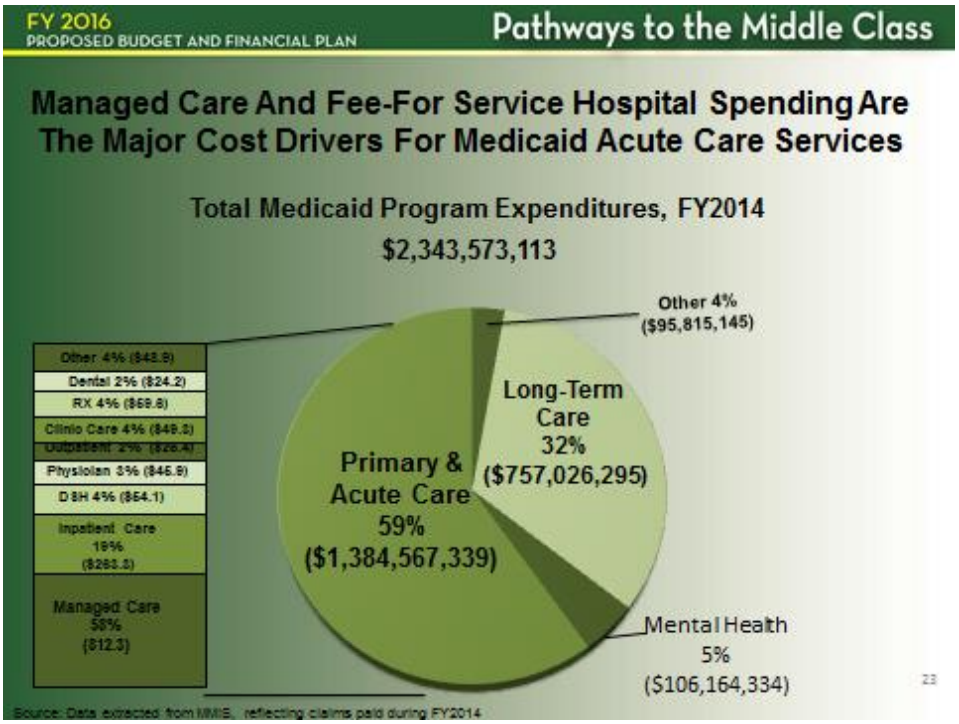
Currently DHCF agency staff are working on developing new reimbursement methodologies for home health care agencies

Centers the latter will be cost neutral. In addition, changes will be required to reduce the payment methodology for the ICF/IDD programs so that the rates can be brought in line with federal Upper Payment Limit restrictions.

Passage of the BSA for these and possibly other policy changes will improve our chances of implementing all revisions to reimbursement methodologies by October 1, 2015, thus ensuring

Key Medicaid Spending Trends and Budget Challenges

Madam Chairwoman, the final section of my presentation highlights a few spending trends in the program in FY2016. Using FY2014 data, the graphic on page 10 of my testimony illustrates the routine way that we organized the $2.3 billion in spending for the Medicaid program across two major types of care: (1) Primary and acute care services ($1.3 billion or 59%); and (2) Long-term care ($757 million or 32%). Payments of $812.3 million to our managed care plans and $283.2 million paid directly to hospitals for care provided to our fee-for-service beneficiaries and the uninsured, together accounted for nearly 80% of spending on primary and acute care.

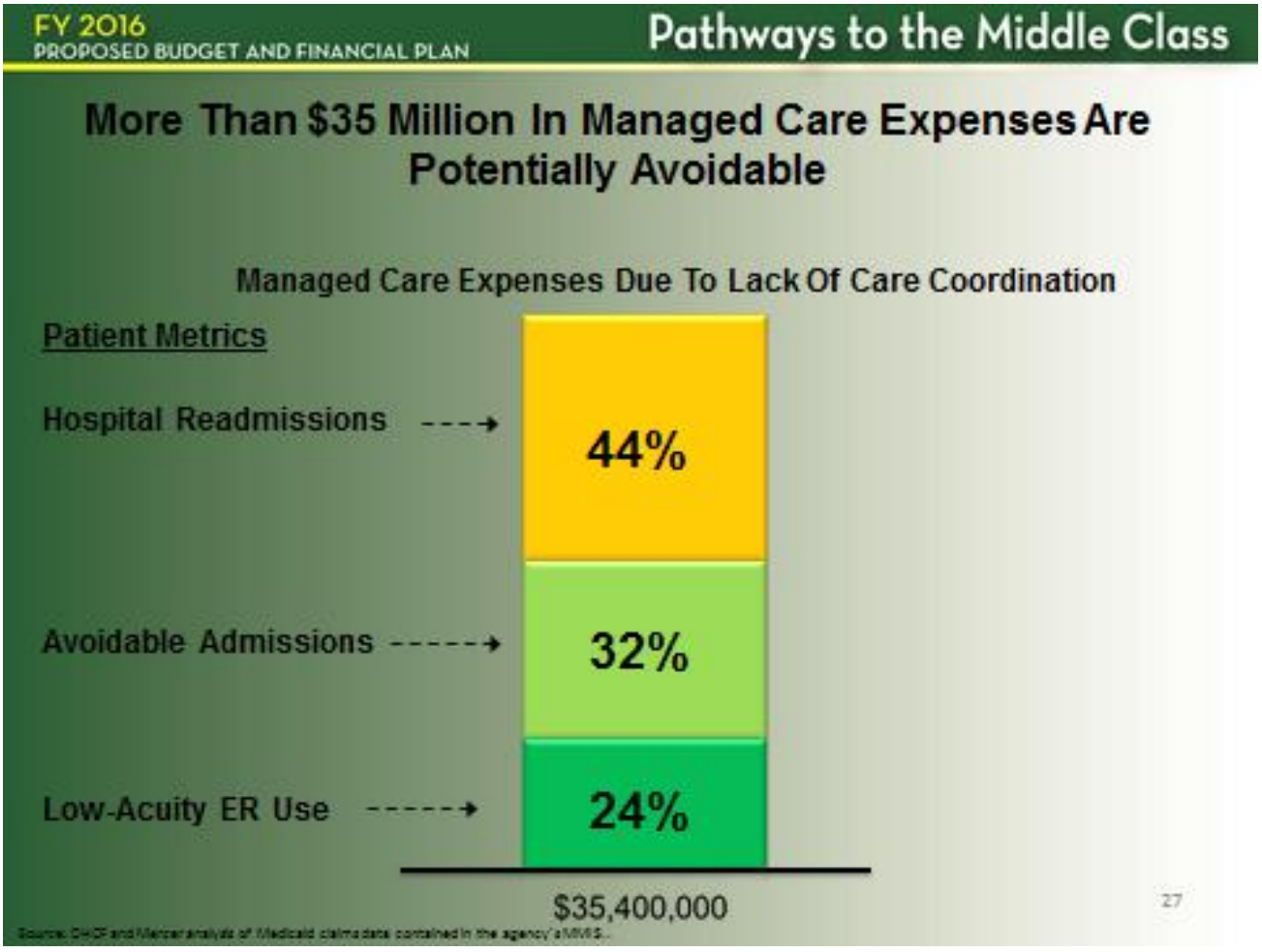


Clearly payments to hospitals are a major cost in the Medicaid program consistent with the outpatient, emergency, and high-end critical care offered in these facilities for Medicaid beneficiaries. Combined,

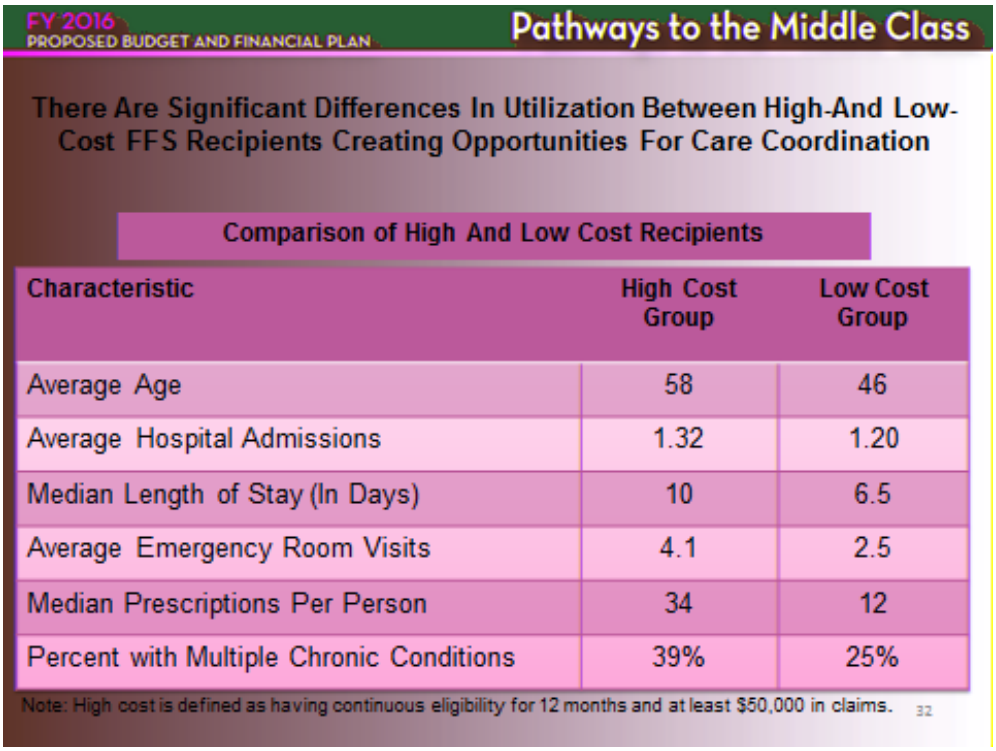
roughly $720 million on hospital-based services in FY 2014. To this end, one challenge we face

is the need to perform far more effectively in managing our beneficiar use of hospital-related services on both the managed care and fee-for-service side of the Medicaid program.

For our three full-risk base managed care organizations, the graphic on page 11 shows that these health plans spent more than $35 million on beneficiaries hospital-related care that was avoidable. The largest portion of these expenditures -- 44 percent -- was spent on patient hospital readmissions within 30 days of the treatment for the same illness. Another 32 percent was spent on inpatient admissions that could have been avoided through proper care coordination. And, 24 percent of these potentially avoidable expenses were due to the beneficiarie use of the emergency room for low-acuity illnesses.



On the FFS side of the business, we know that there is a group of unmanaged beneficiaries -- nearly 7,100 -- who are heavy utilizers of high-end care. On average we are spending approximately $166,000 per person for their care. As shown by the Table on page 12, these persons are older, make more frequent visits to the emergency room and the hospital, stay almost twice as long once admitted, and receive a large number of prescriptions.


FY 2016 PROPOSED BUDGET AND FINANCIAL PLAN

Pathways to the Middle Class

There Are Significant Differences In Utilization Between High-And Low-Cost FFS Recipients Creating Opportunities For Care Coordination

Comparison of High And Low Cost Recipients

Characteristic	High Cost Group	Low Cost Group
Average Age	58	46
Average Hospital Admissions	1.32	1.20
Median Length of Stay (In Days)	10	6.5
Average Emergency Room Visits	4.1	2.5
Median Prescriptions Per Person	34	12
Percent with Multiple Chronic Conditions	39%	25%

Note: High cost is defined as having continuous eligibility for 12 months and at least $50,000 in claims. 32

Now that we have managed care program and better contain and reduce the fraud that was endemic to our personal care program, this issue -- the proper management of care for Medicaid and Alliance beneficiaries -- both policy and budget. Accordingly, this issue will consume a significant amount of staff time for the remainder of this fiscal year and into FY2016.

As noted in our Oversight Hearing, DHCF plans to address this problem in FY2016 by launching a large scale Health Homes pilot project that will eventually serve 20,000

beneficiaries. Authorized in the Affordable Care Act, the law contemplates a program model that incorporates a team of doctors and social workers who will be charged with the responsibility of integrating and coordinating all primary, acute, behavioral health, and long-term services of the patients assigned to them. Payment models will be designed to create incentives for costs savings and reward improved health outcomes. This concept of treating the person

With respect to the limited effectiveness in coordinating care by the three full-risk health plans, DHCF will introduce a pay for performance program in FY2016 to address this problem. Presently under design, this program will ultimately require the health plans to initiate and execute the necessary care coordination strate readmission rate, avoidable hospital admissions, and use of the emergency room for low-acuity illnesses. Plans that fail to achieve certain outcomes against these and several other metrics will face a reduction in their capitated payment rate.

Conclusion

In closing Madam Chairwoman, I prefer to end my testimony not speaking only of our future challenges but rather to proclaim the very good news in Mayor budget proposal for DHCF. Through continued commitment and investment, the Mayor has ensured that the

not

generate savings by reducing the scope of this coverage.

As for the Alliance program, while the question of how the Administration should revisit the process for recertifying persons in the program is unanswered, there can be no questioning of

the commitment to a program that has no peer in the United States and is fully financed with local funds.

DHCF looks to FY2016 with a spirit of optimism and mind set of achievement. We promise to work closely with this Committee and your staff as we wrestle with ways to address the existing cost pressures in the Medicaid and Alliance program under the general creed of

Madam Chairwoman, this concludes my presentation and I welcome questions from you and the Committee.